EDMUND G. BROWN JR., Attorney General
of the State of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
KENT D. HARRIS, State Bar No. 144804
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-7859
Facsimile: (916) 327-8643

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MANJU SINGH, a.k.a. MANJU BALA SINGH, a.k.a. MANJU BALA 5210 Laguna Crest Way Elk Grove, CA 95758 Registered Nurse License No. 678861 Respondent.	Case No. 2008-353 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about May 8, 2006, the Board issued Registered Nurse License Number 678861 to Manju Singh, also known as Manju Bala Singh and Manju Bala ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2010, unless renewed.

///

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

///

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. In or about September 2006, Resident A was admitted to Bruceville Terrace, a skilled nursing facility located in Sacramento, California, with a diagnosis of end stage COPD.

9. On October 17, 2006, the resident's wife was attempting to feed him lunch. Resident A started choking and the nursing staff asked her to stop as the resident was unable to swallow any longer. Resident A's physician was notified of the resident's change in condition. At 1200 hours that same day, the physician ordered IV morphine sulfate for the resident as follows: "Morphine Sulfate 100 mg/100 ml NS IV drip, Begin @ 1mg/hr, may titrate by 1 mg Q hr. PRN Resp. Distress, comfort, max of 10 mg/hr."

10. Respondent was the medication nurse caring for Resident A. Respondent retrieved the necessary equipment to start the IV morphine. On her way to the resident's room, Respondent told her co-worker, registered nurse N. Q., that she had experience managing an infusion pump with IV antibiotics; however, she was not familiar with setting the rate on the IV pump and requested N. Q.'s help in checking the infusion pump for the correct rate of fusion. N. Q. instructed Respondent to set the infusion pump at *100 ml per hour* or to use number code 100/100. At 1230 hours, Respondent set the pump and started the infusion as N. Q. had suggested and asked N. Q. to check the pump and the setting. N. Q. checked the settings on the pump, and without looking at the medication bag, gave Respondent a "thumbs-up", indicating that the pump was set appropriately. At 1330 hours, Respondent checked on the resident and discovered that the medication bag was totally infused and empty. Respondent retrieved a second IV morphine sulfate infusion bag from the medication room refrigerator and hung it on the resident's infusion pump at a rate of *100 mg per hour*. After a few minutes, Respondent felt that the rate was too fast and decreased the rate to 20 ml per hour. At 1430 hours, Respondent and another nurse went to the resident's room to assess him and found the resident without a pulse or respirations.

///

11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 17, 2006, while employed as a registered nurse at Bruceville Terrace, Sacramento, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as follows:

a. Respondent failed to check the correct dose and rate of infusion of the IV morphine to be administered to Resident A, resulting in a medication error and causing the resident to receive over approximately 150 times the prescribed morphine in a two hour period.

b. Respondent failed to document the administration of the IV morphine on Resident A's medication administration record.

c. Respondent failed to notify her supervisor and Resident A's attending physician immediately upon discovering the medication error.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 8 through 10 above.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about October 17, 2006, while employed as a registered nurse at Bruceville Terrace, Sacramento, California, Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 11 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 678861, issued to Manju Singh, also known as Manju Bala Singh and Manju Bala;

2. Ordering Manju Singh, also known as Manju Bala Singh and Manju Bala, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

///

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/16/08.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SA2007102834
phd; 05/29/2008